TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Carlos Kugler, M.D.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-17-3775-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
August 22, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "POST DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $935.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the Request for Medical Fee Dispute Resolution and determined the Provider is entitled to reimbursement for 1 unit of 99456-RE and 1 unit of 99080-73. Reimbursement for these codes has been issued with appropriate interest. The Carrier contends the Provider is not entitled to reimbursement for the 2 remaining units of 99456-RE."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 7, 2017	Referral Doctor Examination to Determine Return to Work, Extent of Injury, and Disability Work Status Report	$935.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work and evaluation of medical care examinations performed on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 10 – The billed service requires the use of a modifier code.
- 296 – Service exceeds maximum reimbursement guidelines.
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is Carlos Kugler, M.D. entitled to additional payment for procedure codes 99456-RE, billed at $500.00, and 99080-73, billed at $60.00?
2. Is Dr. Kugler entitled to reimbursement for procedure codes 99456-RE, billed at $250.00 and $125.00?

Findings

1. Dr. Kugler is seeking reimbursement for procedure codes 99456-RE, billed at $500.00, and 99080-73, billed at $60.00. Explanation of Reconsideration dated September 1, 2017, indicates that Travelers Indemnity Company (Travelers) reimbursed Dr. Kugler $560.00 for the services in question. No further reimbursement is recommended.
2. Dr. Kugler is also seeking reimbursement for procedure codes 99456-RE, billed at $250.00 and $125.00. 28 Texas Administrative Code §134.235 states, in relevant part, "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting **a division or insurance carrier requested** [emphasis added] RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier 'RE.'"

   Documentation submitted to the division does not support that the examination in question was requested by the division or the insurance carrier. Therefore, no reimbursement is recommended for these services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 19, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.